Employer Group Retiree Program N

* The 2014 Medicare A and B deductibles were not published as of the time of this printing, please read your Medicare and You booklet for the 2014 dollar amounts.

Medicare (Part A) Hospital Services per Medicare Benefit Period

Services	Medicare Pays	Wellmark® Blue Cross® and Blue Shield® Pays	You Pay
Hospitalization [1] Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184*	$1,184* (Part A Deductible)	$0
61st thru 90th day	All but $296 a day*	$296 a day*	$0
91st day and after: - While using 60 lifetime reserve days	All but $592 a day*	$592 a day*	$0
- Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses	$0 [2]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care [1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148 a day*	Up to $148 a day*	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1] A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[2] NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days provided in the policy's "Basics Benefits." During that time, the hospital is prohibited from billing you for the balance on the difference between its billed charges and the amount Medicare would have been paid.

NOTE: Medicare benefits are subject to change.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. THIS IS AN EMPLOYER GROUP RETIREE PROGRAM.

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Medicare (Part B) Medical Services per Calendar Year

Services	Medicare Pays	Wellmark Blue Cross and Blue Shield Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147* of Medicare-Approved Amounts [3]	$0	$0	$147*
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
First $147* of Medicare-Approved Amounts [3]	$0	$0	$147*
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare Parts A & B

Services	Medicare Pays	Wellmark Blue Cross and Blue Shield Pays	You Pay
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment: - First $147* of Medicare-Approved Amounts [3]	0%	0%	$147*
- Remainder of Medicare-Approved Amounts	80%	20%	$0

[3] Once you have been billed for the first $147* of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Wellmark Blue Cross and Blue Shield Pays	You Pay
Foreign Travel Emergency Care NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
- First $250 each calendar year	$0	$0	$250
- Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Choose one of the Group MedicareBlue℠ Rx plans below for your prescription coverage

Basic ($70 per month)

Drug Level	31-Day Supply (retail pharmacy)	90-Day Supply (mail order and preferred pharmacy)
Tier 1: Generic Drugs	$10 copay	$20 copay
Tier 2: Preferred Brand Drugs	$30 copay	$60 copay
Tier 3: Non- Preferred Brand Drugs	$50 copay	$100 copay
Tier 4: Specialty Tier Drugs	$50 copay	$100 copay
Supplemental Drugs [1]	25% coinsurance	25% coinsurance
Coverage Gap	$10 copay for Tier 1: Generic Drugs	$20 copay for Tier 1: Generic Drugs

[1] The amount you spend on supplemental drugs does not apply toward catastrophic coverage.

Plus ($96 per month)

Drug Level	31-Day Supply (retail pharmacy)	90-Day Supply (mail order and preferred pharmacy)
Tier 1: Generic Drugs	$10 copay	$20 copay
Tier 2: Preferred Brand Drugs	$25 copay	$50 copay
Tier 3: Non- Preferred Brand Drugs	$40 copay	$80 copay
Tier 4: Specialty Tier Drugs	25% coinsurance	25% coinsurance
Supplemental Drugs [1]	25% coinsurance	25% coinsurance
Coverage Gap	N/A – same copays as above	N/A – same copays as above

[1] The amount you spend on supplemental drugs does not apply toward catastrophic coverage.

Medicare Part D Deductible: Both Group MedicareBlue Rx plans pay the $325 Medicare Part D deductible for you. You will not pay this amount. **Specialty Drug Coverage:** Medicare classifies certain unique and high-cost medications as specialty drugs. These include injectable antibiotics, transplant drugs, certain chemotherapy drugs and other self-injectable or administered drugs. **Supplemental Drugs:** Group MedicareBlue Rx coverage includes some drugs that Medicare does not cover and are not on Wellmark's formulary. You can purchase these select drugs for a 25 percent coinsurance.

Coverage Gap
Medicare (Part D) drug plans have several phases of coverage: the initial coverage period, the coverage gap or "donut hole," and the catastrophic coverage period. During the initial coverage period, you will pay copays for your drugs based on the plan design and tier on which your drug resides. If/once your Total Yearly Drug Costs equals $2,850; you will enter the donut hole. In the donut hole:

- For the **Plus** plan (formerly called Gold plan), you pay the same copays as in the initial coverage period (no change) for all drug tiers.
- For the **Basic** plan (formerly called Silver plan) you will pay up to a $10 copay for generics, and may receive up to a 52.5 percent discount on select brand-name drugs eligible for the Medicare Coverage Gap Discount Program.

You will remain in the donut hole until your True Out-of-Pocket (TROOP) costs reach $4,550. This amount is calculated from the amounts that **you** pay in your copays not the full cost of the prescriptions. After your TROOP costs reach $4,550, you hit the catastrophic coverage period where the Plus and Basic plans cover drugs under the same cost share structure during the catastrophic coverage period: $2.55 for covered generic or multi-source preferred brand drugs, and $6.35 for all other covered drugs; or 5 percent of the cost of covered drugs.

Total Yearly Drug Costs determine when a member enters the coverage gap stage. Total yearly drugs costs are the amounts that you, the member, **and** your prescription drug plan have paid for covered drugs in that calendar year. This does not include any premiums.

TROOP or True Out-of-Pocket Maximum equals the costs used to determine when a member enters the catastrophic coverage stage. "Total out-of-pocket drug costs" refers to the amounts you, the member has paid for covered drugs in a calendar year. This does **not** include the amount that your prescription drug plan has paid, any costs related to supplemental drugs, or premium you pay. If you should change Prescription Drug plans in the middle of the year to another Medicare Part D plan, your TROOP follows you and you will receive credit for amounts already paid under the prior plan.

If you enroll in the Basic plan, once the $2,850 figure is reached by the amounts that you have paid in your copays **and** the amounts that your prescription drug plan has paid, going forward into the gap, only **your copays** from the start of the calendar year will count towards reaching the total of $4,550 to get you out of the gap and into catastrophic coverage. Any money the drug plan had paid for your prescriptions does not apply toward reaching catastrophic coverage at $4,550.

For example:
Mary paid $680 in prescription copays and Basic paid $2,170 and she has now entered the gap/donut hole. Mary will start back at $680 and has to reach $4,550 in her copays plus any money paid by the 52.5 percent discount on brand name drugs by the manufacturer for her to reach catastrophic coverage. The money the prescription drug plan paid for her ($2,170) to make her reach the gap/donut hole does not apply to get her out of gap/donut hole.

If you enroll in the Plus plan, once the $2,850 figure is reached, you do not have to worry about the coverage gap/donut hole. The Coverage gap/donut hole does not apply to you. You will continue to pay your copays as in your initial coverage period. If you reach the $4,550 amount in your copays, you will enter the catastrophic coverage period and pay reduced copays as described above.

Group MedicareBlue^{SM} Rx (PDP) is a Medicare-approved Part D sponsor. Enrollment in Group MedicareBlue^{SM} Rx (PDP) depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments and restrictions apply. Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.
You must continue to pay your Medicare Part B premium.